DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A revisit was completed at Laurelbrook Sanitarium on June 4, 2012, following acceptance of an Allegation of Compliance and Plan of Correction to remove the Immediate Jeopardy cited at K063. The revisit revealed the corrective actions implemented on May 31, 2012 removed the Immediate Jeopardy at K063. Other deficiencies previously cited and not addressed on the Allegation of Compliance remain outstanding. The facility is required to submit a plan of correction for all outstanding defeciencies.	{K 000}		
{K 021} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by:	{K 021}	K 021 1) Door was adjusted on 5/29/12 to close to a positive latch. Doors were re-tested by the maintenance supervisor and confirmed that the doors were working properly. ___ 2) Door was adjusted on 5/29/12 to close to a positive latch. Doors were re-tested by the maintenance supervisor and confirmed that the doors were working properly. All doors were verified to be in working order according to manufacturer recommendations. 3) Maintenance supervisor will perform weekly fire door checks	6/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marsha Fray by Ronald Osterle	President	6-20-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 021}	Continued From page 1 Based on observation, the facility failed to assure corridor fire doors will close to a positive latch upon activation of the fire alarm system. The findings include: Observation on May 14, 2012 at 4:05 p.m. revealed the fire doors on the east corridor near patient room one failed to close to a positive latch upon activation of the fire alarm during the fire drill exercise. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 021}	and report on their working order. Exhibit # 52 4) On 5/31/12 Maintenance Supervisor added to weekly check list to check all fire doors for operation according to manufacturer specifications. This weekly report will be reported quarterly at the QA meeting. Quarterly, the administrator will audit all maintenance log books for accuracy and completeness, report to the QA committee, and ultimately to the board of Laurelbrook Sanitarium and School, Inc.	
{K 038} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure fire doors are clear and free from obstructions. The findings include: Observation on May 14, 2012 at 2:47 p.m. revealed the exit passage door leading to the outside of the basement exit way was blocked by a lattes fence and would not open freely. Based on observation, the facility failed to assure exit access is arranged where exits are readily accessible at all times in accordance with 7.1.	{K 038}		

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{K 038}	Continued From page 2 The findings include: Observation on May 14, 2012 at 2:47 p.m. revealed the exit leading from the basement has no clear, smooth hard surface to a safe area of refuge. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 038}	Supervisor checked all doors for smooth, hard surface to a safe area, and added to quarterly check list to check all doors for proper operation and clear of obstructions. Quarterly, the administrator will audit all maintenance log books for accuracy and completeness, report to the QA committee, and ultimately to the board of Laurelbrook Sanitarium and School, Inc.	
{K 050} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure staff members are familiar with proper fire drill procedures. The findings include: Observation during a fire drill conducted on May 14, 2012 at 4:10 p.m. revealed the person discovering the fire was not familiar with the proper fire drill policies and was instructed by the administrator of the proper procedures. Further observations revealed staff members moving	{K 050}		

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{K 050} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure staff members are familiar with proper fire drill procedures. The findings include: Observation during a fire drill conducted on May 14, 2012 at 4:10 p.m. revealed the person discovering the fire was not familiar with the proper fire drill policies and was instructed by the administrator of the proper procedures. Further observations revealed staff members moving	{K 050}		

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		K 050	service will be conducted on a weekly basis for four weeks during the month of June. Following this, we will do monthly fire drills as required. Maintenance supervisor will be responsible for in-servicing all personnel and performing required fire drills and documentation. 4) Fire drills and in-service documentation will be kept by the maintenance Supervisor as required. Quarterly, the administrator will audit all maintenance log books for accuracy and completeness, report to the QA committee, and ultimately to the board of Laurelbrook Sanitarium and School, Inc. Exhibit # 59	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{K 050}	Continued From page 3 patients from the front lobby and placing them in the west wing corridor for safety. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 050}		
{K 051} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure	{K 051}		

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{K 051}	Continued From page 4 the manual fire alarm pull station is located within five (5) feet from the exit door. The findings include: Observation on May 14, 2012 at 3:00 p.m. revealed the manual fire alarm pull station in the laundry room was located in the center of the room and was not accessible to the staff exiting the laundry to the outside at the exit door. Based on observation, the facility failed to assure the fire alarm system released all approved locking hardware devices in the path of egress. The findings include: Observation on May 14, 2012 at 4:10 p.m. revealed the courtyard gate has a locking hardware device that did not release upon activation of the fire alarm system during the fire drill exercise. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 051}	document their proper operation. The maintenance supervisor will instruct all fire alarm contractors that pull stations must be installed according to current fire codes. 4) Fire safety documentation including proper operation of fire doors and fire gates will be kept by the maintenance Supervisor as required. Quarterly, the administrator will audit all maintenance log books for accuracy and completeness, report to the QA committee, and ultimately to the board of Laurelbrook Sanitarium and School, Inc. Exhibit # 50	
{K 052} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	{K 052}		

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{K 052} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	{K 052}	K 052 1) Fire alarm tests are conducted by Building Systems Technology, and the documentation is included with this deficiency. Documentation will now be kept with other fire documentation with the maintenance supervisor, and a copy with the administrator. Included with the deficiency response are the tests from 2/29/12, 8/2/11, and 2/15/11 and 8/24/10.	6/5/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 052}	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the fire alarm system is maintained to ensure the safety of the residents. The findings include: Observation and interview with the maintenance director, on May 14, 2012 at 5:15 p.m. revealed no documentation for the fire alarm system was available at this time for the inspection. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 052}	2) Fire alarm tests are conducted by Building Systems Technology, and the documentation is included with this deficiency. Documentation will now be kept with other fire documentation with the maintenance supervisor, and a copy with the administrator. Included with the deficiency response are the tests from 2/29/12, 8/2/11, and 2/15/11 and 8/24/10. 3) Documents will be kept in the maintenance supervisor's log book, as well as with the administrator.	
{K 054} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview with maintenance director and record review, the facility failed to assure smoke detectors were tested for sensitivity every two (2) years. The findings include: Observation and interview with maintenance director on May 14, 2012 at 5:46 p.m. revealed the facility failed to provide documentation that a	{K 054}	4) Documentation will be kept by the maintenance Supervisor as required. Quarterly, the administrator will audit all maintenance log books for accuracy and completeness, report to the QA committee, and ultimately to the board of Laurelbrook Sanitarium and School, Inc. Exhibit # 51 Exhibit # 56	

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{K 052}	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the fire alarm system is maintained to ensure the safety of the residents. The findings include: Observation and interview with the maintenance director, on May 14, 2012 at 5:15 p.m. revealed no documentation for the fire alarm system was available at this time for the inspection. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 052}		
{K 054} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview with maintenance director and record review, the facility failed to assure smoke detectors were tested for sensitivity every two (2) years. The findings include: Observation and interview with maintenance director on May 14, 2012 at 5:46 p.m. revealed the facility failed to provide documentation that a	{K 054}	K 054 1) Smoke detector tests are conducted by Building Systems Technology, and the documentation is included with our response to this deficiency. Documentation will now be kept with other fire documentation with the maintenance supervisor, and a copy with the administrator. 2) Smoke detector tests are conducted by Building Systems Technology, and the documentation is included with our response to this	6/5/12

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{K 054}	Continued From page 6 two (2) year sensitivity test was performed on the fire alarm smoke detectors within the facility. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 054}	deficiency. Documentation will now be kept with other fire documentation with the maintenance supervisor, and a copy with the administrator. 3) Documents will be kept in the maintenance supervisor's log book, as well as with the administrator.	
{K 062} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the sprinkler system was maintained. The findings include: 1. Observation on May 14, 2012 at 2:35 p.m. revealed one (1) of five (5) sprinkler heads in the kitchen near the hood area had a heavy build up of grease and dirt. 2. Observation on May 14, 2012 at 4:48 p.m. revealed the facility failed to provide a weekly fire pump log performed by staff maintenance personnel. 3. Observation on May 14, 2012 at 2:40 p.m. revealed numerous areas in the basement had wiring supported by the sprinkler piping. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 062}	4) Documentation will be kept by the maintenance Supervisor as required. Quarterly, the administrator will audit all maintenance log books for accuracy and completeness, report to the QA committee, and ultimately to the board of Laurelbrook Sanitarium and School, Inc. Exhibit # 51	

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{K 054}	Continued From page 6 two (2) year sensitivity test was performed on the fire alarm smoke detectors within the facility. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 054}		
{K 062} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the sprinkler system was maintained. The findings include: 1. Observation on May 14, 2012 at 2:35 p.m. revealed one (1) of five (5) sprinkler heads in the kitchen near the hood area had a heavy build up of grease and dirt. 2. Observation on May 14, 2012 at 4:48 p.m. revealed the facility failed to provide a weekly fire pump log performed by staff maintenance personnel. 3. Observation on May 14, 2012 at 2:40 p.m. revealed numerous areas in the basement had wiring supported by the sprinkler piping. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 062}	K 062 1) Smoke detector tests are conducted by Building Systems Technology, and the documentation is included with our response to this deficiency. Documentation will now be kept with other fire documentation with the maintenance supervisor, and a copy with the administrator. 2) Smoke detector tests are conducted by Building Systems Technology, and the documentation is included with our response to this deficiency. Documentation will now be kept with other fire documentation with the maintenance supervisor, and a copy with the administrator. 3) Documents will be kept in the maintenance supervisor's log book, as well as with the administrator.	6/5/12

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		K 062	4) Documentation will be kept by the maintenance Supervisor as required. Quarterly, the administrator will audit all maintenance log books for accuracy and completeness, report to the QA committee, and ultimately to the board of Laurelbrook Sanitarium and School, Inc. Exhibit # 53 Exhibit # 48	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{K 064} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure fire extinguishers complied with the requirements of NFPA 10. The findings include: Observation on May 14, 2012 at 2:30 p.m. revealed the K class fire extinguisher located in the kitchen was blocked by a metal serving table. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 064}	K 064 1) On 5/31/12 Chattanooga Fire Protection relocated K-Class fire extinguisher in the kitchen. 2) Starting 5/31/12 the Dietery Manager will in-service all staff regarding space requirements for fire safety equipment. 3) Starting 5/31/12 the maintenance department, during monthly fire extinguisher checks, will make sure that nothing is blocking them. The maintence department staff have been in-serviced on this procedure on 6/1/12. Exhibit # 55 4) Starting 6/1/12 the Maintenance Supervisor will report a list of any fire extinguisher problems to the QAPI Committee quarterly and ultimately the Administrator will report to the Board Quarterly.	6/5/12
{K 067} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure fire dampers were maintained in accordance with NFPA 90A.	{K 067}		

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{K 064} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure fire extinguishers complied with the requirements of NFPA 10. The findings include: Observation on May 14, 2012 at 2:30 p.m. revealed the K class fire extinguisher located in the kitchen was blocked by a metal serving table. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 064}		
{K 067} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure fire dampers were maintained in accordance with NFPA 90A.	{K 067}	K 067 1) On 5/31/12 Goins Heating & Air Conditioning checked damper for the every four year required maintenance. Ventilator flow fans have been installed on 6/1/12 in clean linen storage areas in the basement by maintenance staff..	6/5/12

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{K 067}	Continued From page 8 The findings include: Record review and interview with the maintenance director on May 14, 2012 at 5:30 p.m. confirmed the facility failed to perform the 4-year required maintenance to fire dampers. Based on observation, the facility failed to assure the proper air flow is maintained throughout the building. The findings include: Observation on May 14, 2012 at 2:50 p.m. revealed the three (3) clean linen storage areas in the basement has no positive air flow installed. Based on observation, the facility failed to assure the HVAC system is maintained in accordance to the manufacturer ' s specifications. The findings include: Observation on May 14, 2012 at 3:52 p.m. revealed the installed floor heater in patient room one has no protective cover and the heating coils were exposed. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 067}	Floor heater cover has been replaced in patient room 1 by maintenance staff on 5/31/12. 2) On 5/31/12 the maintenance Supervisor checked all rooms for missing covers on heating coils. 3) On 6/1/12 the Maintenance Supervisor will start doing a Room/Bath/Equipment Fall Risk Assessment Form. This form will be completed on a quarterly basis. Exhibit # 57 4) Starting 6/1/12 the Maintenance Supervisor will report a list of room repairs done or in process to the new QAPI Committee on a quarterly basis and ultimately the Administrator will report to the Board Quarterly.	
{K 144} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	{K 144}		

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{K 067}	Continued From page 8 The findings include: Record review and interview with the maintenance director on May 14, 2012 at 5:30 p.m. confirmed the facility failed to perform the 4-year required maintenance to fire dampers. Based on observation, the facility failed to assure the proper air flow is maintained throughout the building. The findings include: Observation on May 14, 2012 at 2:50 p.m. revealed the three (3) clean linen storage areas in the basement has no positive air flow installed. Based on observation, the facility failed to assure the HVAC system is maintained in accordance to the manufacturer ' s specifications. The findings include: Observation on May 14, 2012 at 3:52 p.m. revealed the installed floor heater in patient room one has no protective cover and the heating coils were exposed. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 067}		
{K 144} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1.	{K 144}	K 144 1) On 5/31/12 maintenance staff installed emergency lighting in the generator area.	6/5/12

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{K 144}	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide the emergency generator panel control room with battery-powered emergency lighting. The findings include: Observation on May 14, 2012 at 4:10 p.m. confirmed the emergency generator location was not provided with battery-powered emergency lighting. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 144}	2) On 5/31/12 maintenance staff checked emergency lighting by the generator for operation. 3) Starting 5/31/12 the Maintenance Supervisor will take all inspection reports for life safety to the QAPI committee for review. 4)) Starting 6/1/12 the Maintenance Supervisor will report any recommendations from life safety inspector to the new QAPI Committee on a quarterly basis and ultimately the Administrator will report to the Board Quarterly.	
{K 147} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure electrical wiring is installed in accordance with NFPA 70. The findings include: Observation on May 14, 2012 at 2:45 p.m. revealed two (2) electrical junction boxes in the basement area contained low-voltage wiring has no protective covers installed.	{K 147}		

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{K 067}	Continued From page 8 The findings include: Record review and interview with the maintenance director on May 14, 2012 at 5:30 p.m. confirmed the facility failed to perform the 4-year required maintenance to fire dampers. Based on observation, the facility failed to assure the proper air flow is maintained throughout the building. The findings include: Observation on May 14, 2012 at 2:50 p.m. revealed the three (3) clean linen storage areas in the basement has no positive air flow installed. Based on observation, the facility failed to assure the HVAC system is maintained in accordance to the manufacturer ' s specifications. The findings include: Observation on May 14, 2012 at 3:52 p.m. revealed the installed floor heater in patient room one has no protective cover and the heating coils were exposed. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 067}		
{K 144} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	{K 144}	K 144 1) On 5/31/12 maintenance staff installed emergency lighting in the generator area.	6/5/12

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{K 144}	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide the emergency generator panel control room with battery-powered emergency lighting. The findings include: Observation on May 14, 2012 at 4:10 p.m. confirmed the emergency generator location was not provided with battery-powered emergency lighting. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 144}	2) On 5/31/12 maintenance staff checked emergency lighting by the generator for operation. 3) Starting 5/31/12 the Maintenance Supervisor will take all inspection reports for life safety to the QAPI committee for review. 4)) Starting 6/1/12 the Maintenance Supervisor will report any recommendations from life safety inspector to the new QAPI Committee on a quarterly basis and ultimately the Administrator will report to the Board Quarterly.	
{K 147} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure electrical wiring is installed in accordance with NFPA 70. The findings include: Observation on May 14, 2012 at 2:45 p.m. revealed two (2) electrical junction boxes in the basement area contained low-voltage wiring has no protective covers installed.	{K 147}		

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{K 144}	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide the emergency generator panel control room with battery-powered emergency lighting. The findings include: Observation on May 14, 2012 at 4:10 p.m. confirmed the emergency generator location was not provided with battery-powered emergency lighting. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 144}		
{K 147} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure electrical wiring is installed in accordance with NFPA 70. The findings include: Observation on May 14, 2012 at 2:45 p.m. revealed two (2) electrical junction boxes in the basement area contained low-voltage wiring has no protective covers installed.	{K 147}	K 147 1) Electrical junction boxes in the basement had their covers replaced on 5/15/12 by Maintenance Supervisor. 2) On 5/16/12 the Maintenance Supervisor checked all basement and resident care areas for any junction box missing a cover and replaced any that were missing. 3) On 5/31/12 checked facility for missing junction boxes covers. This	6/5/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 147}	Continued From page 10 This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on May 14, 2012.	{K 147}	will be done on a quarterly basis by the Maintenance Supervisor. Exhibit # 53 4) Starting 5/31/12 the Maintenance Supervisor will report a list of any missing junction box covers to the QAPI Committee quarterly and ultimately the Administrator will report to the Board Quarterly.	